

methods for the serodiagnosis of syphilis seems to be a step forward to a more rapid and simple aid to the investigation of syphilis.

It is suggested that when the diagnosis of syphilis is supported only by repeated Kahn reactions (the testing of the Wassermann reaction not being easily available) this new test should be used as a controlling factor in the diagnosis.

Whenever disagreement occurs between these tests, repeated serological investigations should be made at different laboratories.

Seiler's S.S. test for syphilis will correspond with the Wassermann reaction to within 1 per cent.

I would like to thank Dr. C. G. Welch, M.D., D.P.H., Chief County Medical Officer, Bedford, for his encouragement to me in writing this report.

I am very much indebted to Sister Turner and Mr. Wootton for their whole-hearted cooperation in the preparation of this paper.

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SUBCUTANEOUS FIBROID SYPHILOMATA

This condition, which is one of the rare manifestations of late syphilis, is characterized by the presence of firm nodules in the subcutaneous tissue. These nodules are often multiple, usually occur in the neighbourhood of the larger joints (namely, elbow, knee and ankle) and may be symmetrical in distribution; juxta-articular nodule is consequently a customary synonym. They are firm in consistency, are usually painless and vary in size from that of a split pea to a hen's egg. The process of formation is a chronic one, with little tendency to become necrotic or to invade the overlying skin or associated structures, such as muscle, tendon-sheath or bone. In some cases trauma appears to precipitate their development, and this factor may explain their characteristic site round the larger joints which are daily subject to minor degrees of trauma. The nodules develop between three and twenty-five years after an initial infection which has remained untreated, but tend to be a late manifestation often associated with other signs of tertiary syphilis. The serological tests for syphilis show strongly positive results. In general, the histological picture shows masses of necrosis and occasional giant cells may be seen; typical tubercles are absent. The correct clinical diagnosis is seldom made until either biopsy or a positive report after routine blood tests has aroused suspicion of the true aetiology. Treatment usually leads to the disappearance of the nodules, the rate of response depending upon the density of the fibrosis, which in turn is governed by the duration of the gummatous process.

Case report

A soldier aged 43 years was admitted to hospital with traumatic synovitis of the left knee joint and was transferred to our care on 25th April 1944. He had been married for 21 years and had three living children, aged 15, 12 and 6 years, respectively. His wife had had two miscarriages some 15 and 12 years previously. In 1927 he had sustained an injury to the left elbow. Any history of venereal disease or its treatment was denied. Routine Wassermann and Kahn tests, however, were both reported as giving strongly positive results.

Clinical examination did not reveal any abnormality in the cardiovascular system, central nervous system, lungs, abdomen, skin or mucous membranes. Abnormal physical findings included a mild synovitis of the left knee and multiple firm painless subcutaneous nodules, unattached to skin or other structures, and situated in the lower half of the arm and upper third of the forearm on the extensor aspect of the left elbow. The patient was uncertain when these nodules had developed but he thought that it was soon after the injury to his elbow. X-ray examination showed some undue bowing of the upper third of the left ulna with irregularity of the olecranon process, probably due to a previous fracture. Radiography of the left knee and the cardio-aortic shadow did not reveal any abnormality. The positive blood Wassermann and Kahn tests were confirmed; cerebrospinal fluid examination was negative. Biopsy was performed on one of the nodules. The naked-eye appearance was that of a firm

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white ovoid encapsulated node, $14 \times 10 \times 6$ millimetres. The cut surface was homogeneous, firm and white. Section showed a fibrous granuloma with focal chronic inflammatory infiltration, tending to concentrate round blood vessels which showed endarteritis. Some necrosis was present but caseation or well formed giant cells were not seen.

Treatment with iodides by mouth and bismuth oxychloride injections was commenced on 2nd May 1944. By 13th June 1944, after 1.45 grammes of bismuth, all the nodules had disappeared and only a slight thickening of one or two small areas of the subcutaneous tissues could be felt over the lower insertion of the triceps.

Comment

Subcutaneous fibroid syphilomata have been described in the British literature by Parkes Weber, by Worster-Drought, by Lane and by Wakeley. The condition is mentioned by Stokes and was the subject of articles by Kalz and Newton, by Goodman and Young and by Wangenstein. Wakeley thought that subcutaneous fibroid syphilomata should be distinguished from juxta-articular nodules, which Davey considered to be a late manifestation of yaws, but study of later reports suggests that the disease process is similar and that the two terms are largely synonymous. It has been suggested that these nodules might be confused with subcutaneous nodules of rheumatic origin, but we feel that the differentiation should not present difficulty. The triceps is a favourite site for localized gumma of muscle, a condition which one of us has described elsewhere (Laird), but such tumours are less freely movable than are subcutaneous fibroid syphilomata.

The three essentials of accurate diagnosis are the presence of other evidence of syphilis, characteristic findings on histological examination of the lesion and an adequate response to antisyphilitic treatment. The case herewith reported satisfies these diagnostic criteria and is of especial interest in virtue of the asymmetrical distribution of the syphilomata, the probable association with trauma and the very rapid and complete resolution of the nodules during therapy with iodides and bismuth.

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DIAGNOSIS OF SYPHILIS AFTER PENICILLIN TREATMENT FOR GONORRHOEA

In the report of Suchet's paper in the December number of the *Journal*, the risk of masking syphilis by treating with penicillin a concurrent infection of gonorrhoea is discussed. This danger appears to be very real and consequently the case reported on below is of interest.

An Indian soldier aged 24 years was admitted to this hospital ship from a troopship with the diagnosis of gonorrhoea. He was suffering also from acute conjunctivitis of the left eye and right inguinal adenitis. He gave a history of exposure to infection, on one occasion only, 14 days before admission; there was no previous history of venereal disease. In the troopship gonococcal urethritis had been diagnosed microscopically and he had been treated with 25 grammes of sulphathiazole. The conjunctivitis had responded well to protargol and hot bathing.

On admission to hospital the patient had a temperature of 103°F , and a pulse rate of 86. There was a resolving left conjunctivitis but no discharge; the right eye was normal. The right inguinal glands were enlarged and very tender. In the left groin there were a few hard painless glands. There was some balanitis. The foreskin was long and not fully retractable, and at its edge there were two small dirty superficial irregular ulcers; in association with the